‘it Is Beyond Our Reach’: Policies and Infrastructure Influencing Postpartum Care in Rural Kenya

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Research Article

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Abstract

Background

Maternal mortality in low middle-income countries is still high. Like most countries in Sub-Saharan Africa, the progress towards reducing maternal mortalities in Kenya is slow. Approximately 488 women out of every 100,000 live births die during the childbearing process. Kenya has put in place several strategies to mitigate maternal mortalities. For instance, Kenya introduced free maternity services in 2013 to remove financial barriers to skilled health services for mothers and children under five years old. Hence, it is necessary to explore how the policies and infrastructure intersect with other socioeconomic factors to influence postpartum care in rural Kenya to mitigate maternal and infant deaths.

Methods

This qualitative research conducted in-depth focused ethnographic (FE) interviews with 23 nurses and midwives working in nine health centres and the County Hospital in Nandi County, Kenya, between July 2017 and February 2018. We used thematic analysis approach as described by Braun and Clarke to analyze the data. Lincoln and Guba criteria for establishing the trustworthiness of data was used.

Results

The analysis of data generated six themes. The findings from the theme, *Policies and Infrastructure Influencing Postpartum Care* will be discussed in this paper. The findings will be discussed under three sub-themes *1) Free maternity services, 2) Adherence to perinatal care guidelines, and 3) Recruitment and retention of nurses and midwives.* Facilities lacked the essential equipment and supplies required to provide these services, recruitment and retention of staff, demotivation of healthcare providers, lack of regular training and supervision of staff, and lack of adherence to postpartum guidelines. These issues intersected to determine the quality of skilled postpartum services provided to childbearing women and their families as well as women and infants' overall perinatal health outcomes.

Conclusion

The findings have underscored the importance of having a functional healthcare system that supports both the clinical and emotional aspects of the women and healthcare providers. Efforts should be directed into addressing the negative factors influencing care provision at the facility level. Suboptimal care could cause women not to attend skilled health care and sabotage the global goals of eliminating maternal and infant mortalities. This can be achieved by creating policies that considers the diverse causes and power-relations withing the healthcare organization.

Background

Appropriate postpartum services have been effective in reducing maternal and infant mortalities. However, the maternal and infant deaths in low middle-income countries are still unacceptably high.

According to the World Health Organization (WHO), the maternal mortality rate (MMR) decreased by about 38% worldwide [1]. However, the maternal mortalities in low middle-income countries are still high, with approximately 810 women dying from preventable causes related to pregnancy and childbirth, and 94% of these deaths occurring in low resource settings [1]. Like most countries in Sub-Saharan Africa, the progress towards reducing maternal mortalities in Kenya is slow. According to the Kenyan demographic and health survey health in 2014, approximately 488 women out of every 100,000 live births die during the childbearing process [2]. While skilled workers conduct as little as 62% of births, 51% of women receive postpartum check-ups in the first two days after the infant is born, and even lower in rural areas, at 43% [2]. The rates are troubling, given that almost 40% of women in Kenya experience complications during the postpartum period, and 15% of these are life-threatening [3].

Acknowledging the importance of postpartum care, the WHO recommends skilled care for mothers within six hours after birth, then follow up visits within 72 hrs, seven to fourteen days, six weeks, and six months [4]. These recommendations have saved many lives, but women in low-middle income countries are still dying during childbirth due to preventable complications such as postpartum haemorrhage, sepsis, pre-eclampsia, and other complications from pregnancy and delivery. However, researchers continue to identify the "Three Delays" contributing to maternal mortality in low middle-income countries (LMIC): 1) delay in deciding to seek skilled delivery care; 2) delay in reaching an appropriate health facility; and 3) delay in receiving appropriate care at the health facility [5]. These delays have been linked to socioeconomic factors, for example, the financial status of the women, family income, education of the women, geographical locations, and transportation to the health facilities, and long wait lines at the health [6, 7, 8, 9].

Kenya has put in place several strategies to mitigate the loss of mothers during the childbearing process. For example, Kenya introduced free maternity services in 2013 to remove financial barriers to skilled health services for mothers and children under five years old [3]. Other measures include the training, hiring and retaining nurses and midwives initiatives, and maternal and child health programs that support skilled health during the perinatal period [10]. Nevertheless, the free maternity services increased the number of women utilizing perinatal services. Still, the quality of care diminished due to the high volume of patients and less staff in health care facilities [11]. Further, the Attitudes of healthcare providers is known to influence women's decision to utilize skilled health [6]. In their study, Abuya and colleagues noted that women in Kenya who experienced disrespect and abuse from health care providers were less likely to seek skilled health [6].

In this paper, we draw from our qualitative research data collected in 2017 on the experiences of nurses and midwives providing postpartum care in rural Kenya. Nurses and midwives are instrumental in providing postpartum care in rural Kenya. Postpartum care provides the mothers and infants with an opportunity to be assessed by skilled healthcare providers such as nurses and midwives. Nurses and midwives provide high-impact and low-cost interventions within communities [12]. They screen mothers and infants for any complications or potential complications following childbirth and educate them on detecting postpartum complications and what to do if a complication occurs [12]. However, several

barriers that influenced the nurses' and midwives' care for mothers and infants during the postpartum period were identified in this study. These barriers include insufficient knowledge and skills to manage and prevent postpartum complications, lack of individual professional development, limited time to provide quality care due to inadequate staffing, inadequate physical space within the facilities, inconsistent availability of basic supplies and equipment, poor access to essential drugs, lack of supervisor/management support, unclear healthcare policies, and undependable transport to the health facility due to poor geographic terrain. Procedures and processes drive nurses and midwives within the healthcare system that interact at the individual or structural level to influence the postpartum care services.

Methods

Theoretical frameworks

The perspectives of Critical theory (CT) and Foucault's concept of knowledge and power guided the study's methodology. CT assumes that individuals, groups, and society are influenced by social-economic, political, and cultural factors surrounding them and examines complex modes of social domination and the possibilities for change with the context [13]. Past experiences immensely influence perceptions; hence, CT research generates knowledge to explain how things could be and not just how they are [14]. Similarly, Foucault states that power relations are rooted in social networks where history is distinct and defines the authority within which power relations function [15]. To Foucault, power produces facts, with individuals being vessels of knowledge production [16]. These lenses were critical in the study, given the authority that the nurses and midwives possess over the women by knowledge. However, due to the lack of necessary supplies and equipment, nurses and midwives in rural Kenya were powerless regarding mobilizing resources to curry out perinatal services. The powerlessness caused disempowerment to the nurses and midwives. At the same time, the women in their own space have cultural knowledge about childbearing. These power experiences influenced the work of the nurses and midwives in rural Kenya and helped generate new knowledge in the provision of perinatal services.

Research methodology: This qualitative study utilized the focused ethnography (FE) methodology. Ethnography is used to understand descriptions and patterns of behaviors of individuals and groups of people within a culture [17]. Since the study analyzed the culture of nurses and midwives in rural Kenya to determine their experiences, the researcher chose FE because it is a targeted form of ethnography. Studies utilizing FE have a specific research question conducted among a small group of people within a particular context or organization [18]. The research question for this study was: What are the experiences of nurses and midwives providing postpartum care in rural Kenya? The lead author grew up and practiced as a nurse and midwife in rural Kenya and thus had extensive knowledge of the culture of rural health facilities. Nurses and midwives work in collaboration with other healthcare providers to provide care to the women and infants during perinatal care. Our research seeked to emphasis the facilitators and barriers to the nurses’ and midwives’ work while providing postpartum care service. Hence, FE was

appropriate for our research since we targeted a small group (nurses and midwives) providing postpartum care [19]

The use of FE allowed us to understand the contexts of postpartum care in rural Kenya from the perspectives of the nurses and midwives, as well as consider our own views [17]. We acknowledged the multiple realities that the participants and researchers contribute to the knowledge development throughout the research process.

Study Setting

The study was conducted among nurses and midwives working in nine health centres and the County Hospital in Nandi County, Kenya. Nandi County is a mixed terrain area located in the west Rift-Valley province of Kenya [2]. The County's primary mode of transportation is by road, with most roads being highly inaccessible during the rainy seasons. Very few people own cars, with most utilizing public transit. Most people in Nandi County are Nandi, a sub-group of the Kalenjin tribe. The Nandi are culturally/traditionally rich in most aspects of their daily lives.

Participant recruitment

Participant recruitment posters were posted on visible bulletin boards at each facility. Purposeful sampling was used to recruit study participants. Purposeful sampling is a non-probability sampling method in which the researcher selects participants based on a personal judgment about who will be the most informative [20]. All nurses and midwives who had provided postpartum care in Nandi County health centres and County Hospital for a minimum of two years were eligible to participate in the study. Using the representative of the nurses' association as key informant to recruit participants. Data saturation was reached after in-depth individual interviews of 23 participants. The sample sizes for qualitative research are generally smaller than quantitative research [20]. The process of initially inviting all nurses and midwives providing postpartum care services in Nandi County to participate enabled open access to the study population. The researcher provided an information letter to nurses and midwives working at the study sites. Participants received a written informed consent to participate in an individual interview and focus group discussion, which they signed before initiating data collection. The consents included permission to tape or digitally record the interview and focus group sessions. Participants were also assured of confidentiality, and each participant was assigned a research code instead of using his or her name. The researcher maintained confidentiality throughout, and the nurses and midwives who agreed to be participants were not released to their supervisors.

Ethics

Ethics approval was obtained from the University of Ottawa Research Ethics Board (REB) and the Institutional Research and Ethics Committee (IREC) in Kenya.

Analysis of data

Data was collected between July 2017 and February 2018 using individual in-depth interviews and a focus group discussion. The researcher kept reflexive notes throughout the data collection process. Data collection and analysis occurred concurrently. Thematic analysis, as elaborated by [21], was used to analyze data. Thematic analysis was appropriate because it is flexible and provides a rich, detailed, and complex dataset. Following each interview, data were transcribed, read, and the researcher noted initial ideas. The researcher noted initial ideas, identifying cultural ideas and recurrent patterns. Using a Word document, the researcher systematically generated initial codes and collated codes into potential themes. The researcher then developed clear definitions and names for each theme. The researcher and thesis supervisor held several coding and data analysis meetings. The aspects of trustworthiness (credibility, transferability, dependability, and confirmability) as outlined by [22], were used to ensure the trustworthiness of the research process.

Results

The analysis of data generated six themes. The findings from the theme, *Policies and Infrastructure Influencing Postpartum Care* will be discussed in this paper.

Knowing that the experience of childbirth is unique to every woman, nurse, and midwife in this study managed expectations of their clients during the postpartum period by promoting a trusted environment where their clients felt safe. Several policies and processes have been put in place to promote maternal and child health outcomes. These policies influence the day-day work of the nurses and midwives. They acknowledged that the policies and processes could achieve better health outcomes for the women and infants if adhered to. The findings will be discussed under three sub-themes *1) Free maternity services, 2) Adherence to perinatal care guidelines, and 3) Recruitment and retention of nurses and midwives.*

Free Maternity Services (FMS)Policy

The Free maternity services (FMS) policy was introduced in all government facilities in 2013. This policy aimed to promote skilled perinatal services and eventually reduce maternal and infant mortality and morbidity. Most participants in this study acknowledge that there has been an increase in women seeking professional health services. However, it comes with its challenges, such as long wait times and lack of supplies at the healthcare facilities.

It's a bit challenging because as per now, most of the clients are aware of the “beyond zero programs” where we are supposed to provide free maternity services. Unfortunately, we lack supplies most of the time. So it becomes a bit challenging because you want them to come to deliver at the hospital, then when they reach the hospital set-up, there are no supplies, so they are forced to buy … some are not able to buy…So you hear comments from the people in the community, “if we go to the hospital, we will still be sent to buy this and that, we better move to our nearby midwife who can assist us and we pay back.” It’s a good initiative by the government whereby they want all mothers to deliver in the health center but the shortage of supplies makes it a bit challenging for us to do our work. (P022)

The participants reported missing opportunities for the women and infants to obtain care at the health facilities. This is disheartening for the mothers, given the many hurdles they face in accessing skilled health services.

We have many mothers coming to us especially with the free maternity being offered but sometimes they are too many for us to even see them and some end up going back home without being seen by the nurse. The mothers get tired of waiting in lines. Sometimes the babies are hungry, the mother is hungry too and so they prefer to go back home instead of waiting in line the whole day. (P016)

With the FMS, the national government is to reimburse health care facilities money for the cost incurred from maternity care services. However, participants reported compromised quality of care because of inadequate essential drugs, supplies and equipment at the health facilities due to the delayed reimbursement.

The government has promised to provide free maternity care, but apart from promising, there are some challenges we encounter…It is free, but we have encountered a lot of challenges in the provision of supplies. We cannot give good care if we don't have the supplies. Because we depend on reimbursement of free maternity, we find that we encounter some challenges because the money is not paid. Although the government will was good, it is not as effective as we thought it could be. (P014)

Another issue that compromised the quality of care was the limited space in the health facilities. Despite the increase in mothers utilizing perinatal services, the building infrastructure remained the same. Women and infants are then forced to share the few available beds with others or sleep on the floor, posing a risk for infections.

For example, in our postnatal care unit, since they introduced the free maternity, we have more mothers coming and we don't have enough equipment to help these mothers. We have fewer beds and it is not convenient for the mothers. For example, you could have like ten mothers and we have only five beds, so it is inconvenient, you find some mothers are sleeping on the floor. (P013)

The participants voiced concerns about privacy when caring for the women and infants. For example, this mother complained about sharing beds with other mothers.

Mothers and their newborns are sharing beds with other mothers with their newborns. The beds are also so small. There is no privacy for the mother when giving health education about her care. This also poses infection prevention problems because of sharing beds. (P010)

Although the FMS is an enabler for the use of skilled health care by women, several factors such as insufficient staffing ratios and lack of essential supplies lead to unsatisfactory care for the women. This has caused the women to abandon or delay seeking skilled healthcare, hence the potential risk for increased morbidity or mortality during the perinatal period.

Adherence to Perinatal Guidelines

Health care providers in Kenya are expected to follow the National Guidelines for Quality Obstetrics and Perinatal Care when providing perinatal services. Participants indicated that a copy of the document is available for reference in all facilities providing reproductive health services. All participants were aware of the postpartum guidelines. However, most participants indicated that implementing all aspects of the procedures was not always possible because of the shortage of staff and lack of appropriate equipment.

To my knowledge, I think the principles are there but implementing them is not sufficient. Yeah, so we are trying to implement these guidelines which have been made. But for them to be implemented, the government … should make sure that the services to the patients are upheld to some level … I told you earlier that they need to equip all the rural facilities both with the manpower and also with the equipment. (P013)

Nurses and midwives were knowledgeable on how to treat obstetric emergencies, and most of them had received training on emergency obstetric care. Yet, the lack of essential resources to provide care makes it difficult for them to attend to these emergencies.

Yes, we have standard operational procedures on the walls.… we have been trained on the Emergency obstetric care management. So it is easy to follow the operational procedures because we know … sometimes it is hard for us but we are trying (both laugh). We are trying because sometimes you know you are supposed to work according to the guidelines, but you are forced to improvise a few things. Most of the time we improvise because we don't have the proper equipment and supplies. (P021)

They communicated to the women throughout the process to make informed decisions related to their health and well-being, such as family planning and infant spacing. These positive relationships promoted women empowerment and autonomy and enhanced positive health outcomes for the mother and infant.

You know, we see some of these mothers from when they are pregnant, during the antenatal clinics … Others come only to deliver … How we treat these mothers when we see them is important because if they are not happy with us, they will not come back to deliver the baby at the hospital … So, we get to know them, and they get to know us. We get to understand these women during the process…(P004)

The nurses and midwives assessed and provided appropriate postpartum care information to the women. They determined the vulnerability of the women and newborns by considering their age, parity, level of education, and general ability to take care of the infants. They provided emotional support to the women and maintained women's rights and dignity, and respect.

After delivery, the mothers are normally anxious, and some do not know what to do. During assessment, we encourage them. We listen to them. We explain the procedures that we are doing to them before we begin. We educate them and encourage them to ask questions. This way, when we ask them to come back after six weeks for postnatal care of the baby and for themselves, they come back because we provide good care. (P008)

A mother who has given birth is generally a happy mother. So, if you find otherwise, then you probe … You can also obtain the history from the relatives. Some will also tell you this mother is like this when she gives birth. Sometimes we must refer the mothers to the psychiatrist if we determine they need more help than we can offer. (P016)

Some participants acknowledged rushing through their assessments so that they can attend to as many women as possible, placing women at risk for impending complications.

So, we normally do quick assessments to these mothers and miss other things because we have to rush to the others waiting in line" (P016)

Participants indicated that on some occasions, women are discharged from the health facilities less than 48hrs following delivery due to lack of space in the health centres.

What we normally do, because of the congestion in the hospital, we don't keep them for the two days that we are supposed to keep them. So they just stay overnight, and then the following day in the morning, if everything is stable, and the baby is OK, we just discharge them through the family planning and MCH which is the infant wellness infant clinic. (P012)

Further, the inconsistent availability of essential supplies probed unsafe organizational practices such as the rationing of basic supplies such as gloves, putting the women, infants, and nurses and midwives at risk of complications and infections. In most cases, participants reported that women were asked to purchase essential supplies required for their care at the health facility.

Sometimes we are just given two boxes of gloves and we are supposed to miraculously use them for three days before going back to the supply store to get more…many times, we run out of some important drugs like oxytocin. The mothers are asked to buy gloves so that we can use when assessing them. You know how important that drug is for a mother immediately following birth…We do not have a constant supply of water, the pump is down, like more than 50% of the time. So, in those instances …we have to get it from a small well outside and a few tanks outside that we have for reservoir …We need tap water, running water, you know, when fetching water with a jug (laughs), you don't feel it's enough hygiene especially if you have to clean up the place after delivery … Yeah. It is quite a challenge. (P012)

The integration of services, such as prevention of mother-to-child transmission (PMTCT), has allowed better uptake of the services and hampered the quality of care the women receive at the health facilities during postpartum visits. Participants were also concerned with the essential infrastructure in the health facilities.

We have so many programs like PMTCT that seem to have more priority than postpartum care. These programs have taken the space that we used to care for the mothers during postpartum care, and now all the mothers [antenatal and postpartum] are taken care of in the same ward. The bed is also too high for the mothers climb after delivering the baby. (P022)

On the other hand, women, especially those who are not first-time mothers, still delay seeking skilled health care services during the perinatal period. As such, they arrive at the healthcare facilities with complications such as postpartum haemorrhage, puerperal sepsis, or respiratory distress.

Those who have delivered many children assume it is normal to deliver at home on their own or with TBA. If it is precipitate labor, they deliver at home, they do not care what next. But then they find themselves with complications like sepsis, engorged breasts.

That is when they now come to hospital because of the complications. Sometimes we have to refer them to the county referral hospital. (P001)

Equipping healthcare facilities with better refan ambulance or access to the ambulance has improved the referral systems within the facility levels. However, there is still a need for basic supplies to manage emergencies.

With the introduction of ambulances, it has become better of but maybe the health centres should be equipped so that we can deal with emergencies. Sometimes you lack whatever you want for resuscitation no oxygen you get any child that is not breathing very well managing that child is a challenge at the health centres but at the district, I think they can manage. (P004)

Women expect quality and safe care for both themselves and their infants from the healthcare providers. The nurses and midwives in rural Kenya have appropriate education and a unique approach to providing respectful and dignified postpartum services. Utilizing the available resources, they promoted women and infant health outcomes through healthy relationships. However, all facilities need to be equipped with proper equipment, supplies, and human resources to succeed in postpartum guidelines.

Recruitment and retention of nurses and midwives

There was a consensus among all participants regarding the shortages of staff in health care facilities. "Our staffing ratios are so low, and it makes our work difficult" (P010), irrespective of the many qualified nurses without employment in Kenya.

One that we cannot get by is staffing…So I find that as a challenge that is almost beyond reach. Because first, we don't have enough representation as nurses in the management positions … The solution to that one, I am not sure but because we have many trained nurses in the County who are not employed, just waiting for an opportunity, they should be hired even on contract … They just need to hire a few nurses on contract. Because when they hire on contract, it's not a lot of money. It's about half the salary. So they can just hire some of them on contract for a few years that will relieve the shortage. (P012)

Participants indicated that despite the shortages of nurses in healthcare facilities, some nurses remain unemployed. They recommended that the government increase the healthcare budget so that more nurses and midwives can be hired, especially in the health centers. Health centers are more likely to receive obstetric emergencies as they are closer to the communities than the referral hospitals.

There are so many qualified nurses out there looking for jobs… we are overworking. Especially the staffing in the health centers is worse than the referral hospital. Because at the health centers, you can find that there is only one nurse at work and maybe a clinical officer is [all that is] there. The night always has one nurse at some of the health centers. (P021)

The staff shortages hindered the effectiveness of the postpartum services in rural facilities because of the limited contact of nurses and midwives with their clients.

Staffing is more challenging. We have very few nurses attending to so many mothers. We don't even have enough time to provide the education required to the mothers before they are discharged home because we are rushing to the next mother who has just delivered. (P002)

In some situations, a facility could have only a nurse/midwife on duty, with several patients to attend to. Such situations left the nurses helpless and demotivated.

Shortage of staff. Because we have only two nurses in the health center, sometimes you can find yourself working alone because the other nurse is sick. And there could be 4 mothers waiting to deliver. So you find it is difficult and you don't even know what to do (P18)

And some a faced with situations where they must triage between two emergencies when they are the only skilled practitioners in the facility.

Sometimes you find you are alone and you have go round to all sections, immunization, outpatient, delivery room… you find there is another challenge where the two can collide let's say another personal comes with bleeding abortion and comes and find another mother in 2nd stage labour…you will be running up and down which one will you help first? (P001)

This shortage of nurses and midwives in the health facilities has led to an informal increase in the scope of practice for the nurses and midwives. In addition to their work, they are now offering complex services that specialists would typically provide, causing role overload to the nurses and midwives and placing women and infants at risk.

Being in the health center or dispensary, you are doctor, you are the nurse, you are the subordinate, you are the everything … It affects one in such a way that you cannot do what you are supposed to do, like the observation in hourly or half hourly as per the guideline (P004)

It is essential to address the barriers to postpartum care in the healthcare facilities for women and infants to receive competently, quality, and safe healthcare services from the nurses and midwives. This entails equipping the healthcare facilities with the essential equipment and supplies required to provide adequate care, ensuring appropriate staffing, and ensuring nurses and midwives are regularly updated with the current postpartum care best practices.

Discussion

Several factors still intersect to determine postpartum care in rural areas of low middle-income countries like Kenya, despite the high maternal mortality and morbidity. The sustainable development goal (SDG 3.1) aims to reduce maternal deaths to less than 70 per 100,000 live births by the year 2030 [23]. Many African countries have embraced free maternity services (FMS), which removes the financial barriers and improve access to skilled health care [24]. The FMS has increased the number of women utilizing perinatal services. For instance, [25] used data from Demographic and Health Surveys from 10 African countries concluded that removing the user fees for maternity services was associated with an increase in the births in health care facilities and a decrease in neonatal mortality. Similarly, a study in Ghana concluded that providing free care increased facility deliveries, especially for the poor [26].

Given the current high rates of maternal mortality, it is evident that it is not enough to encourage women to utilize perinatal services. Women require dignified, quality and evidence-best care that will promote positive outcomes during the perinatal period. Nurses and midwives are the largest groups of healthcare providers in Kenya. They provide perinatal services close to the communities to prevent unnecessary delays from accessing skilled healthcare, especially in rural Kenya's poor road infrastructure. However, nurses and midwives are faced with several barriers when providing postpartum care. Although the nurses and midwives in this study were knowledgeable on postpartum care practices, they indicated that on most occasions, they were unable to follow the postpartum guidelines and policies due to a lack of essential supplies and time. The lack of basic supplies such as gloves also places nurses, midwives, and women at risk for HIV and Hepatitis diseases and decreased the quality of care within the health facilities. Suboptimal care could cause women not to attend skilled health care. Similar results were reported in South Sudan [27] and Zimbabwe [28]. Further, our study noted that improper assessment because nurses and midwives rushing placed women at risk for further postpartum complications. Failure to adhere to postpartum guidelines could influence women and infants' health outcomes and influence future utilization of these services by women [27].

Women who feel respected, empowered, and trustful relationships with healthcare providers have better postpartum psychological outcomes [29]. Although there was no evidence of disrespect and abuse in this study, some studies have reported disrespect, and abuse of the women at the healthcare facilities hinders women from utilizing perinatal services (Abuya et al., 2015, 30,31,32,33]. In their thematic analysis of women experiences in Western Kenya, [34] concluded that responsiveness, supportive and dignified care, and effective communication contributed to positive experiences of the mothers during the perinatal period. The study also indicated inconsistency in care among healthcare providers within the same facility [34]. Given that responsive care is an essential aspect of postpartum care, it is necessary to research why there are inconsistencies among health care providers' service delivery. Abuse and disrespect have been reported by several studies in Kenya and Sub-Saharan Africa, and it was unusual that our study findings were not congruent. This could be because we only interviewed nurses and midwives and did not get perspectives of the women and other healthcare providers.

Training and supervision of health care providers to provide quality and culturally responsive care have proven to increase the quality of care of women and infants, including early referrals [35, 36, 37, 31] For

countries such as Kenya to move forward the SDG 3.1, there is a need to invest in nursing education, retention, and professional growth activities. Nurses and midwives require opportunities for training and mentoring in research and policy development for them to meaningfully participate in decision making within their healthcare facilities, and the health system [38, 39]. The training and supervision should also translate to other healthcare professionals who collaborate with the nurses and midwives.

Another critical issue raised by the participants in this study was feeling devalued and demotivated to do their job due to the unhealthy work environment created by the shortage of staff and essential supplies. The hiring and distribution of human resources, compensation, the capacity for career development, hospital infrastructure, resource availability, supervisor involvement, and personal recognition all play a significant role in retaining workers [40]. Opportunities to participate in continuous education were diminished with due to shortage of staff and lack of supervisor support [41]. Continuous education promotes empowerment for healthcare providers such as nurses and midwives and motivates them to implement changes in their daily work routine [42]. Hence, to move forward towards SDG 3.1, there is an urgent need to examine the influencers and barriers to perinatal services from healthcare providers, women, and the organization perspectives. Policies and practices that examines and addresses the intersection of these barriers and influencers at all levels of healthcare (individual, community, organization levels) are necessary for addressing maternal and infant mortality in low-middle income countries such as Kenya.

Conclusion

The findings have underscored the importance of having a functional healthcare system that supports both the biopsychosocial aspects of the women and healthcare providers. It is not enough to encourage women to utilize skilled health services during the perinatal period. Efforts should be directed into addressing the negative factors influencing care provision at the multiple levels of the system starting with close attention to the rural facility level. This includes the assessment and analysis of the diverse issues and power-relations that influence postpartum care in rural areas. These efforts include providing healthcare practitioners with the resources required to interact with women and identify potential postpartum complications. Suboptimal care causes poor health outcomes and discourages women from seeking skilled health care, thus sabotaging the global goals of eliminating maternal and infant mortalities. This calls for the County health managers and other decision makers to advocate for adequate perinatal care resources including ensuring a consistent supply of the required equipment and pharmacological as well as non-pharmacological supplies. As well, having clear policies that guide the threshold of the minimum necessary supplies in each facility, steady running water and electricity in the facilities, and preventative maintenance of the equipment in each facility. Healthcare providers require regular clinical updates, as well as training on culturally appropriate and respectful care.

Study Limitation

Although the study captured the experiences of nurses and midwives providing postpartum in rural Kenya, some limitations could have influenced the study results. The nurses and midwives were on a national strike during the data collection. The strike could have affected their responses during the interviews. This study did not include the nursing supervisors and other health care professionals as study participants. Including them would have provided a different dimension of the health service provision, such as an administrative level perspective, which would highlight institutional and systemic level barriers to perinatal service delivery.

Declarations

Ethics approval and consent to participate: Ethics approval was obtained from the University of Ottawa Research Ethics Board (REB) (File Number: H02-17-18), and the Institutional Research and Ethics Committee (IREC) in Kenya (Reference: IREC2017/39). We obtained a voluntary signed informed consent to participate from each participant prior to participating in the interviews. Participants were also assured of confidentiality, and confidentiality was maintained throughout the research process. The first author completed a Tri-Council Policy Statement: Ethical Contact for Research involving Humans Course on Research Ethics (TCPS2:CORE), prior to initiating the research process.

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